STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF KOKOMO	3025 W. SYCAMORE STREET KOKOMO, IN46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure Survey. Survey dates: September 27 and 28, 2011 Facility number: 011075 Provider number: 011075 AIM number: N/A Survey team: Donna M. Smith, RN, TC Tammy Alley, RN Toni Maley, BSW (September 27, 2011) Linn Mackey, RN (training) Census bed type: Residential: 33 Total: 33 Census payor type: Other: 33 Total: 33 Residential sample: 7 These state findings are cited in accordance with 410 IAC 16.2. Quality review completed on October 4, 2011 by Bev Faulkner, RN	R0000	The following is the Plan of Correction for Sterling House of Kokomo in regards to the Statement of Deficiencies for the annual survey completed on 9/28/2011. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0042	(p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observations and interview, the facility failed to ensure the most recent completed survey was included in the survey book for the residents, families and/or visitors review for 1 of 2 days observed during the survey. This had the potential to affect 33 of 33 residents, families and/or visitors in the facility. Findings include: 1. On 9/27/11 at 9:15 a.m., the survey book was observed on the table in front of the office area. The most recent survey present in this survey book was a complaint survey conducted on 8/17/10. There was no information related to the annual survey completed on 10/05/10. 2. On 9/28/11 at 8:25 a.m., during an interview the Administrator indicated she did not know why the last survey was not located in the book.	R0042	***R 042: Resident Rights (non-compliance) What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · The community has consistently had a practice of keeping copies of their survey letters and findings in a binder on a table outside the Executive Director's office, with a sign directly overhead, stating its location. · On the date in question, the surveyor found the most recent survey letter to be missing from this binder. · This survey letter was one page only-stating the community was deficiency-free on their last annual survey. · It has not been determined who would have removed the letter, as all other surveys were still in the binder. · Once the Executive Director was notified, she immediately obtained a copy of the deficiency-free letter and placed it in the binder, and notified the surveyors of its presence. How will the facility identify other residents with***	10/15/2011

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			the potential to be affected by the same alleged deficient practice and what corrective action will be taken? · Residents and interested parties had the potential to be affected by the alleged non-compliant practice. · Anyone who was having difficulty locating the survey results will now be directed by an enlarged sign to check the binder directly below the sign, and/or if moved by a resident or visitor, advising the interested party to ask the Executive Director or any associate for their own copy. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · Anyone who was having difficulty locating the survey results will now be directed to check the binder, and/or ask the Executive Director for their own copy, in the event something has been removed. · An audit tool will be placed in the survey binder and the contents are to be audited daily by the Executive Director/Designee. · There is now a note in the survey binder directing readers who want to make copies to have someone in the Wellness Center make a copy for them, instead of removing any of the contents.	

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			· Associates will receive education on the new directive and will be available to make copies for any visitors wishing to receive one from a duplicate file which will be kept in the wellness center. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? · The Executive Director/Designee will review results of audits weekly and make recommendations/changes, based on the findings and recommendations of the QA committee.By what date will these systemic changes be implemented? · 10-15-11 at corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · The community has consistently had a practice of keeping copies of their survey letters and findings in a binder on a table outside the Executive Director's office, with a sign directly overhead, stating its location. · On the date in question, the surveyor found the most recent survey letter to be missing from this binder. · This survey letter was one page only-stating the community was deficiency-free on their last annual survey. · It has not been	

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			determined who would have removed the letter, as all other surveys were still in the binder. · Once the Executive Director was notified, she immediately obtained a copy of the deficiency-free letter and placed it in the binder, and notified the surveyors of its presence. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Residents and interested parties had the potential to be affected by the alleged non-compliant practice. · Anyone who was having difficulty locating the survey results will now be directed by an enlarged sign to check the binder directly below the sign, and/or if moved by a resident or visitor, advising the interested party to ask the Executive Director or any associate for their own copy. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · Anyone who was having difficulty locating the survey results will now be directed to check the binder, and/or ask the Executive Director for their own copy, in the event something has been removed. · An audit tool will be placed in the survey binder and the contents are to be audited daily by the Executive	

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			Director/Designee.· There is now a note in the survey binder directing readers who want to make copies to have someone in the Wellness Center make a copy for them, instead of removing any of the contents.· Associates will receive education on the new directive and will be available to make copies for any visitors wishing to receive one from a duplicate file which will be kept in the wellness center. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Executive Director/Designee will review results of audits weekly and make recommendations/changes, based on the findings and recommendations of the QA committee.***By what date will these systemic changes be implemented?*** · 10-15-11	

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R0090	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

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	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observations and interview, the facility failed to ensure the posting of the survey sign was visible for the location of the survey book for residents, families, and/or visitors review for 1 of 2 days observed during the survey. This had the potential to affect 33 of 33 residents, families and/or visitors in the facility. Findings include: 1. On 9/27/11 at 9:15 a.m., no posting of the location of the survey book was observed. At this same time, the survey book was observed on the table in front of the office area. The most recent survey present in this survey book was the complaint survey conducted on 8/17/10. There was no information related to the annual survey completed on 10/05/10. 2. On 9/27/11 at 8:25 a.m., during an interview the Administrator indicated she had found the survey sign behind several items on the table. She indicated the pamphlets and other items on the table in front of the office would get moved around frequently by the residents. She also indicated the sign should be located	R0090	**R 090 Administration and Management-deficiency** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · The community has consistently had a practice of keeping copies of their survey letters and findings in a binder on a table outside the Executive Director's office, with a large sign directly overhead, stating its location. · On the date in question, the surveyor informed the Executive Director that she was unable to find the sign and did not immediately locate the survey binder on the table below the sign. The sign was pointed out to the surveyor, who then proceeded to inform the Executive Director that she felt the sign was not easy enough to find. · In response, the Executive Director, then immediately replaced a portion of the sign and used 72 point font to direct interested parties immediately below the sign to find the survey binder.· This survey binder was found to be missing one page only-stating the community was deficiency-free on their last annual survey. · It has not been determined who would	10/15/2011

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	on the window sill/shelf above where the survey book was located.		have removed the letter, as all other surveys were still in the binder. It is also impossible to determine why the survey sign was not visible to the surveyor.· A new sign is now in place directing interested parties to view a copy of the survey binder which is available on the table outside the Executive Director's office, and now includes the directive that additional copies may be made by any associate in the wellness center, instead of removing the contents. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Residents and interested parties had the potential to be acted by the alleged non-compliant practice. · Anyone who was having difficulty locating the survey results will now be directed by a new sign to check the binder directly below the sign, and/or if moved by a resident or visitor, advising the interested party to ask the Executive Director or any associate for their own copy. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · Anyone who was having difficulty locating the survey results will now be directed to check the binder, and/or ask the Executive Director	

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			for their own copy, in the event something has been removed. · An audit of the survey binder and the contents will be completed daily by the Executive Director/Designee.· There is now a note in the survey binder directing readers who want to make copies to have any associate in the Wellness Center make a copy for them, instead of removing any of the contents.· Associates will receive education on the new directive and will be available to make copies for any visitors wishing to receive one from a duplicate file which will be kept in the wellness center. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Executive Director/Designee will review results of audits weekly and make recommendations/changes, based on the findings and recommendations of the QA committee.***By what date will these systemic changes be implemented?*** · 10-15-11	

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R0092	(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interviews, the facility failed to ensure fire drills were conducted quarterly on each shift for the fire drills reviewed from 10/10 to 8/11. Findings include: 1. On 9/27/11 at 11:50 a.m., the fire drills were provided by the Administrator. The fire drills were conducted on the date and time as follows: 10/13/10 at 3:30 p.m.; 11/19/10 at 8:19 a.m.; 12/20/10 at 7:20 a.m.; 1/05/11 at	R0092	**R 092 Administration and Management-non-compliance** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · No resident was affected by the alleged non-compliant practice. · The Maintenance Director previously in charge of drills is no longer employed at this community. · The new Maintenance Director has been educated on the expectation that this community conducts fire drills quarterly on each shift. When drills are conducted between 9	10/15/2011

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	10:00 a.m.; 2/14/11 at 8:45 a.m.; 3/16/11 at 3:20 p.m.; 4/07/11 at 4:45 p.m.; 5/14/11 at 11 a.m.; 6/09/11 at 8:15 (unspecified); 7/20/11 at 10:30 (unspecified); and 8/24/11 at 9:25 (unspecified). 2. On 9/27/11 at 12:10 p.m., the Director of Nursing indicated the shifts were 6 a.m. to 2 p.m.; 2 p.m. to 10 p.m.; and 10 p.m. to 6 a.m. On 9/27/11 at 2:10 p.m., during an interview the Administrator indicated the unspecified times for the above fire drills were conducted in the a.m.'s as determined by the staff attendance. She also indicated the fire drills had not been completed quarterly on all shifts.		pm and 6am, a coded announcement is used instead of an audible one. In addition, the community maintenance director will request and document fire department assistance with a drill at least every 6 months. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Residents and associates have the potential to be affected by the alleged deficient practice.· The new Maintenance Director has been educated on the expectation that this community conducts fire drills quarterly on each shift. When drills are conducted between 9 pm and 6am, a coded announcement is used instead of an audible one. In addition, the community maintenance director will request and document fire department assistance with a drill at least every 6 months. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · Copies of documentation for each fire drill completed at the community will be kept in a location to be designated by the Executive Director.· The Executive Director will review documentation of all fire drills requested and completed monthly to monitor compliance with	

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			expectations. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Maintenance Director will report results of monthly fire drills to the Safety Committee, along with producing written documentation of his attempts to schedule fire drills with the fire department at least every 6 months. · The Executive Director will make recommendations regarding further actions, based on monthly findings and documentation review. ***By what date will these systemic changes be implemented?*** · 10-15-11	
R0144	(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observations, record reviews, and interviews, the facility failed to ensure a clean, safe, and sanitary environment related to the carpeting, wallpaper, doors, dining room curtains, window sills, fluorescent lights, and ceiling vents observed during the annual survey for 1 of 1 observation day. This had the potential to affect 33 of 33 residents residing in the facility. Findings include:	R0144	**R 144- Sanitation and Safety Standards deficiency *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · Apartment 605: Carpet cleaned and bubbled areas were fixed by a local carpeting services vendor.· 500 hallway: wallpaper was repaired.· Apartment 511: Carpet cleaned and repaired.· Wallpaper in the gallery was secured. · Exit door area was cleaned of debris.· Hallway vent	10/15/2011

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	1. On 9/27/11 at 10:55 a.m., the following was observed: Room 605's door was open with the resident observed in the recliner. On the carpet, there were scattered dark brown to black floor areas of varying sizes ranging from quarter size to saucer size. These areas were observed in the middle of the room from the doorway to the recliner at the other end of the room. Also, six bubbled areas ranging from a small ball to a medium sized 1/2 of a ball were also observed throughout this same area. There was brown accumulated debris observed along the door's metal threshold and in the corners at the exit door at the end of this hallway, As one entered the 500 hallway, a 10 inch length area of loose/bubbled out wallpaper was observed above the baseboard at the corner of the hallway. Room 511's door was observed opened. As one entered the room, a 4 inch elongated spilled red area was observed on the floor carpeting in the middle of the room. The carpet was observed buckling up around the baseboard to the bathroom entryway. In the large area in front of the		outside 205 was repainted and caulked.· The carpet in the entry way and inside Apartment 101 was cleaned.· The carpet in the gallery was cleaned.· Scuffs to bottoms of apartment doors and door trim were repainted.· The fluorescent light in the front hallway of the electrical room has been assessed for safety.· The front lobby sitting room windows and ledges have been cleaned.· The Florida room window sills have been cleaned.· In the mechanical room near the nurses station, a cover has been placed over the fluorescent lights.· In the whirlpool room, the vent has been cleaned and the stained area has been repainted.· In the beauty shop, the crack near the baseboard has been patched and the beauty shop thoroughly cleaned.· The ceiling vent in the short hallway near the beauty shop was cleaned and repainted.· The ceiling vent near apartment 106 was cleaned and repainted.· The mechanical room on the 100/200 hall now has a fixture in place.· The storage room with housekeeping supplies has a cover over the fluorescent fixture.· In the gallery, the ceiling vent above the counter was repaired. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Residents have the potential to	

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		A. BUILDING 00 B. WING	09/28/2011

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	gallery/Grandma's kitchen room, several residents were observed attending an activity. In this same area, 18 inches of the wallpaper at the seam near the ceiling was observed coming apart. The exit door at the end of the short hallway behind this large area was observed with an accumulation of brown debris at each end of the metal threshold. The hallway ceiling vent outside Room 205 was observed with a brown bordered stained area measuring an irregular 2 inches wide. In this same stained area, a small quarter sized cracked opening was observed. The carpet in the entry way and in the middle of Room 101 was observed with dark brown stained areas of varying shapes and sizes measuring up to the size of a quarter. The hallway carpeting throughout the facility was observed with various brown to dark gray stained areas of various sizes from saucer size and larger. In the gallery/Grandma's kitchen area, a large area of dark brown/black stained carpeting was observed around the large table and chairs. Entry doors to the individual apartments were observed scuffed below the		be affected by the alleged deficient practice, and are encouraged to report when they notice areas in need of repair within their privately held apartments, and the maintenance director /designee is responsible for documenting follow-up actions in a timely manner.· A general cleaning schedule is in place for common area cleaning. The Executive Director/Designee will be responsible for completion of rounds to audit for compliance. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · Associates will be re-educated by the Executive Director/Designee, regarding common area cleaning expectations. · The Maintenance Director will be re-educated by the Executive Director/Designee on record-keeping for all repairs, both scheduled and un-scheduled. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · Observations and “Ready for Company” Checklist will be utilized by one manager daily for the next 30 days to monitor compliance with acceptable standards. The results of these audits will be kept in a location	

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	doorknobs. The scuffed marks varied in sizes from 1 inch to across the width of the door with paint observed missing from Room 203's door. These rooms were numbers 302, 303, 305, 201, 202, 203, 204, 209, 108, 104, 101, 502, 504, 505, 509, 511, and 405. Also the two attic doors by Room 204, the exit door by Room 604, and Room 513's outside door trim were also observed scuffed up in various areas below the doorknobs. 2. On 9/27/11 from 2:55 p.m. to 3:40 p.m., the environmental tour was conducted with the Administrator and the Maintenance Supervisor. The following was observed: In the front hallway in the mechanical room, the fluorescent light was uncovered with no covering observed over the individual bulbs; As the various scuffed doors to the above specified rooms were observed, the Maintenance Supervisor at this same time during an interview indicated he was trying to "catch up" with the scuffed doors/areas. As the hallway carpeting was observed, the Administrator at this same time during an interview indicated she had hired a company to clean the facility's hallway		determined by the Executive Director, and will be reviewed weekly. Additional recommendations and follow-up will be determined by the Executive Director.***By what date will these systemic changes be implemented?*** · 10-15-11	

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	carpeting. She indicated the stains came through and continue to show up with every attempt to clean the carpeting. Also, in reference to Room 605, she indicated the carpeting had been replaced a year ago. She also indicated she had called the company, who had laid the carpeting, but she had not received a response. In the front lobby sitting room, a layer of light gray to black dust was observed on 3 of the 3 window sills. In the main dining room, 5 of the 5 window sills were observed with a layer of light gray to black dust with a spider web observed in 1 of the 5 windows. The floor length curtains were observed with a layer of gray, accumulated dust on the bottoms of the curtains. Two of the curtain panels were observed with an irregular brown stained line marking extending 6 to 12 inches from the bottom of the curtain panels. In the "Florida" room, the 3 window sills were observed with a layer of light gray, loose dust. In a second mechanical room around the nurse's station, no cover was observed over each of the 3 fluorescent lights.			

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	In the whirlpool room, the ceiling vent was observed with a stained brown/white circle around the vent with the 2nd corner vent observed with gray dust hanging from it. In the beauty shop, upon entering the room, a cracked elongated opening in the wall was observed above the baseboard on the left side of the entry doorway. Also, a layer of light gray to browning dust/debris was observed along the walls of the room. At this same time during an interview, the Administrator indicated the beautician usually cleaned the beauty shop. The ceiling vent in the short hallway by the beauty shop was observed with brown, orange colored stained border around the outside of this vent. In the hallway by Room 106, one side of the ceiling vent was observed with a small area of a stained brown area with a jagged opening next to the vent. At this same time during an interview, the Administrator indicated the ceiling vent's discoloration around them had seemed to start with the melting snow this past winter, and then, the air conditioner added to it this summer. The mechanical room located in the			

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	100/200 hall was observed with no light cover over the fluorescent light fixture. Also, the storage room with housekeeping supplies was observed with no cover on the fluorescent light. In the gallery/Grandma's kitchen room, the ceiling vent above the counter was observed crumbly/cracked on 1 side of the ceiling vent with a brown stained area surrounding this vent. 3. The "NIGHT SHIFT CLEANING SCHEDULE" policy was provided by the Director of Nursing on 9/28/11 at 9:10 a.m. This current policy indicated the following: "...WEDNESDAYS 1. Dust window sills common areas. ...SUNDAYS 1. Sweep/mop beauty shop....."			
R0270	(c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on record review, observation, and interview, the facility failed to ensure that a resident with orders for thickened	R0270	**R 270 Food and Nutritional Services-deficiency** ***What corrective action(s) will be accomplished for those***	10/15/2011

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	liquids and supplements were provided as prescribed by the physician for 1 of 2 residents reviewed for thickened liquids and supplements in sample of 7. (Resident # 25) Findings include: The record for Resident # 25 was reviewed on 9/26/11 at 11 a.m. Current diagnoses included, but were not limited to, dementia and unavoidable weight loss. A recapitulation of physician orders for Resident # 25 for September 2011, indicated an order for nectar thickened liquids and Ensure supplement three times a day at 8 a.m., 12 noon, and 5 p.m. During a lunch observation on 9/27/11 between 12:05 p.m. and 12:40 p.m., Resident # 25 was sitting in her wheelchair at the dinning room table with a glass of thickened water and a glass of thickened lemonade placed in front of her. The resident took on drink of lemonade. CNA # 2 was informed the thickener had settled to the bottom of the glass of lemonade and water. The liquid at the top of the glass was not thickened. CNA # 2 then stirred the liquids for approximately 5 seconds. CNA #2 then walked away,		***residents found to have been affected by the alleged deficient practice?*** · Resident # 25: no adverse effects were noted to this resident as a result of the alleged deficient practice. · Ensure supplements orders are now noted on Medication Administration record to be provided by the nursing staff following meals. · The record will be initialed by the nursing staff to document compliance. · Nursing staff was advised to only supply cool or warm fluids for thickening as opposed to iced fluids, as the thickener will mix more thoroughly. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Other residents with orders for supplements or thickened liquids have the potential to be affected by the alleged deficient practice. For this reason, the Health and Wellness Director / Designee audited the clinical records for all residents with orders for thickened liquids and/or supplement orders. Supplement orders will be transcribed onto the Medication Administration to determine compliance regarding provision of supplements. The nurse or QMA on duty during each meal service will personally supervise the the provision of thickened liquids . **What measures will be put in place**	

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	leaving the resident unattended at the table. The resident then took another drink of lemonade. LPN # 1 was then informed the thickener had settled to the bottom of the glasses of liquids. LPN #1 then stirred the liquids for 10 seconds. The lemonade then thickened, but the water did not. LPN #1 then removed the water and brought back fresh water and placed thickener into the water and stirred. The water then stay thickened. LPN #1, during interview, indicated she did not know why the thickener was settling to the bottom of the glasses. Also observed during the lunch meal, Resident #25 failed to receive her Ensure supplement. During an interview with QMA # 4 at 4 p.m.,on 9/27/11, the QMA indicated the Ensure should have come from the kitchen with the meals. A undated policy titled "TIPS FOR THICKENING LIQUIDS" was provided by the Director of Nursing on 9/28/11 at 9:20 a.m.. the policy indicated "...stir immediately for 10 seconds...Allow 3-5 minutes for liquid to reach desired consistency prior to serving....when using small amounts of thickener for syrup/nectar consistencies there may be steeling. [SIC] Re-stir after 3 minutes for consistent product...."		**or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · Associates who provide meal service were re-educated by the Health and Wellness Director/Designee regarding the supplement and thickened liquid guidelines. · Dining room supervisor is to double-check thickened liquids for appropriate consistency prior to serving to residents. Health and Wellness Director/Designee will audit MAR daily to ensure supplements have been provided and documented as ordered. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Health and Wellness Director/Designee will monitor compliance daily and will report findings to the Executive Director weekly. In the event non-compliance is observed, the executive director will determine next steps for corrective action and follow-up. ***By what date will these systemic changes be implemented?*** · 10-15-11	

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R0414	(k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observations, record review, and interviews, the facility failed to ensure handwashing was completed in a manner to prevent the spread of infections and/or disease for 1 of 1 meal service observed during 1 of 2 days of the survey. This had the potential to affect 33 of 33 residents residing in the facility. (9/27/11) Findings include: 1. On 9/27/11 from 12:15 p.m. to 12:50 p.m., the following was observed as lunch was being served: LPN #1 was observed to wipe a food spill off of the floor with paper towels. She then was observed to handwash for 12 seconds (secs). Next, she was observed to continue to help with the set up of the Resident #18's meal. CNA #2 was observed to handwash, turn the water off with her wet hands, and then dried her hands as she continued to check with the resident in the dining room.	R0414	**R 414 Infection Control-Deficiency** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · LPN #1, C.N.A. #2 and C.N.A. #3 were re-educated by the Health and Wellness Director/Designee on proper hand washing technique with return demonstration. · No residents suffered any apparent adverse effects as a result of the alleged deficient practice. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Other residents as well as associates have the potential to be affected by the alleged deficient practice. · The Health and Wellness Director/Designee has completed a hand washing inservice for associates who assist with meal service. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · The Health and Wellness has posted reminders regarding proper hand washing	10/15/2011

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	CNA #3 was observed to handwash for 10 seconds, served applesauce to an unidentified resident, handwashed for 15 seconds, and continued to serve the prepared food plates to the residents. CNA #2 was observed to continue to pick up the soiled salad/cottage cheese dishes, touched Resident #21's left arm while talking to her, and then, continued to pick up the soiled salad/cottage cheese dishes. No handgel/handwashing was observed. LPN #1 was observed to place a soiled drinking glass on the soiled dish's cart, retrieve a clean drinking glass from the cabinet, and returned to Resident #18's side and began to mix up a drink for this resident. No handwashing/handgel use was observed. CNA #3 was observed to handwash for less than 10 secs, fixed Resident #31's coffee and served it to her. Next, she served Resident #17's prepared lunch plate. No further handwashing/handgel was observed. After picking up several soiled dishes, CNA #2 was observed to handwash for 12 seconds. After CNA #3 was observed to pass another prepared lunch plate, she began to		practices at the common area hand washing sinks for associated to review. · The 20 second hand washing rule as well as safe food handling practices will be part of the orientation training requirement for new associates who handle food. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Manager on Duty and/ or Designee will monitor hand washing technique and document the findings for two weeks. · The hand washing monitoring will continue each shift daily for the next two weeks and monthly thereafter. · Results of the audits are to be provided to the Executive Director monthly for review. · Additional actions will be determined by the Executive Director, based on findings. ***By what date will these systemic changes be implemented?*** · 10-15-11	

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	handwash, readjusted the water during this handwash, and handwashed for a total of 15 seconds. 2. On 9/27/11 at 2:40 p.m. during an interview, LPN #1 indicated one should handwash for the length of the ABC's song. She indicated she did not know how long the time would be. On 9/28/11 at 1:05 p.m. during an interview, CNA #3 indicated one should handwash for 15 secs. She also indicated if the water needed to be readjusted, the water should be readjusted, and the handwashing process should be restarted. On 9/28/11 at 10:40 a.m. during an interview, the Administrator indicated during meal service one should handwash for 20 seconds. 3. The "How to: Hand Washing - Associates" policy was provided by the Administrator on 9/28/11 at 10:40 a.m. This current policy indicated the following: "Purpose: Handwashing is regarded as the single most important means of preventing the spread of infections.... Suggested Guidelines:			

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	1. Appropriate fifteen (15) to twenty (20) second hand washing should be performed in situation including but not limited to: ...* Before touching, preparing, or serving food. ...* After handling items potentially contaminated with any resident's blood, excretions, or secretions. ...Handwashing Procedure: ...2. Wet hands, wrists and forearms with warm (110 F. [Fahrenheit]) running water. 3. Apply soap to palm of hand...working up a lather... ...6. Rinse hands, wrists and forearms thoroughly under warm running water. 7. Dry hands carefully with paper towels. 8. Shut off water with paper towels....."			